BAI
the insurance specialists

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A member of the British American Investment Group of Companies

CLAIM FORM

GROUP COMPREHENSIVE HOSPITALIZATION POLICY

Issuance of this form does not amount to admission of any liability by the company

1. Name of the Insured			
2. Company			
3. Contact Phone number			
4. Details of the person in respect of whom the claim is made			
a. Name			
b. Relationship to the Insured			
c. Past claim details	Year	Amount claimed	Disease/Disorder
5. Nature of injury/ Illness			
a. When was the injury sustained or disease/illness first detected?			
b. Briefly explain injury or illness			
6. Name and address of the Hospital/ Nursing home /Clinic			
a. Date of admission			
b. Date of discharge			
c. Name of attending doctor/GP/Specialist			

7.(To be completed by Hospital/Nursing home/Clinic/General Practitioner/Specialist as the case may be)

a. Are you in agreement with the information provided in this claim form? Yes/No

b. Explain the medical condition of the claimant requiring hospitalization/treatment? (Use additional space, if needed)

c. When did you first examine the claimant?

d. Did the claimant suffer from any pre-existing condition which was responsible for the present disease/illness? Yes/No

e. Are you satisfied that the bills and receipts under item 8 are relevant to this claim? Yes/No

I certify that the information provided in this claim is true and the bills, receipts and services utilized by the claimant were based on my/our recommendations.

Signature with date and seal

8.Enclose original documents

Description	Bill number	Amount
Total		

I hereby declare and affirm that the above statements, particulars, bills and receipts provided as expenses in respect of treatments as per the details true and correct. If any of the above statements, particulars, bills and receipts are false, I agree and understand that the company shall repudiate claim(s) arising hereunder. I hereby give my consent for the company to seek any information or clarification from the above Hospital/attending doct consultant/s and specialist/s on the treatments or illness or disease or injuries in respect of the above claim and/or for any other related matter. I authorize the release of any medical or other information necessary to process this claim.

Dated at..... this.....day of.....200 .

Date

Signature of the Insured